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Issues Brief

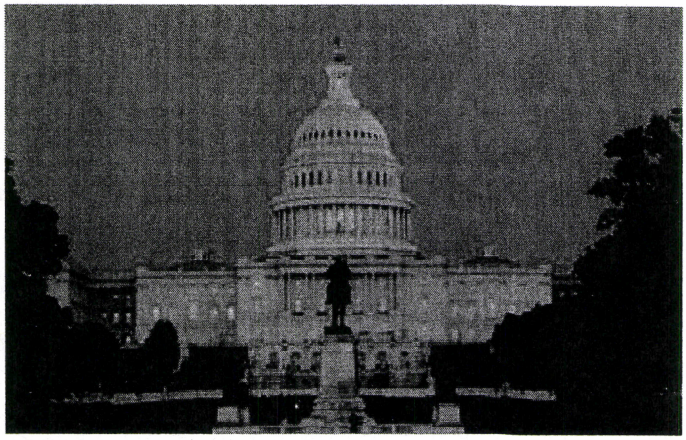
Key Questions Facing States Following the Supreme Court's Ruling on the Patient Protection and Affordable Care Act (ACA)

The Supreme Court decision of June 28, 2012 returns health care reform to the headlines and will likely act as a catalyst to accelerate those initiatives that were on hold pending the ruling. While coverage has primarily focused on the fact that the law was largely upheld, the decision related to Medicaid expansion creates some uncertainty and raises questions for states related to their responsibilities to implement the ACA.

In this Issues Brief, the KPMG Government Institute, in conjunction with the KPMG Global Human and Social Services Center of Excellence, has narrowed the issues to five core questions and provides the following summary of each, along with our recommendations on how state officials might proceed.

1. Should a state move forward with the Medicaid expansion?

   Medicaid expansion is now essentially optional. The decision to move forward on Medicaid expansion is a central decision state policy makers will need to make in the days and weeks ahead. While the answers to the other questions that follow may influence the decision a state makes, a likely important factor will be estimating the long-term cost impact of an expanded Medicaid program on state budgets. These costs may reach into the hundreds of millions of dollars annually for many states, so the decision is significant. There is a straightforward actuarial process we recommend each state go through to collect the data necessary to make a decision. The first step is to confirm the population that would be covered by an expanded program. The second step is to estimate the cost of coverage for this expanded population in 2014, and then to project the growth in that cost through 2020 when the federal cost share will be reduced to 90 percent. This would provide an estimate of the cost impact to states that can be compared with each state's existing cost of coverage for the uninsured in order to help assess the costs and benefits of moving forward with the expansion.



2. If a state does not move forward with expansion, what happens to people between the state's existing Medicaid threshold and 1•• •percent of the federal poverty level (FPL)? Will they be eligible for subsidies?

   The ACA provides subsidies to purchase private insurance through the Health Benefit Exchange (HBE) to individuals above 1•• •percent of the FPL. If a state chooses not to move forward with Medicaid expansion under the ACA, it will leave a new kind of "dynamic void," where an individual is not eligible for Medicaid and also may not be eligible for a subsidy. Even if adjustments can be made by the federal government (either through an act of Congress or the rulemaking process) to the subsidy criteria so that these individuals could obtain a subsidized plan, it is likely that individuals or families at this income level may not be able to afford even the subsidized premium. This would obviously dramatically impact the intended effect of the ACA. We recommend that states engage the federal Center for Consumer Information and Insurance Oversight (CCIIO) in a dialogue around this population and determine exactly how ACA regulations – existing and future – may be impacted.

3. If a state does not move forward with expansion, and is left with uninsured individuals below 133 percent of the FPL who either do not qualify for a subsidy or cannot afford private insurance with the subsidy, will those individuals be subject to the individual mandate and accompanying penalties?

If, in fact, there will be a segment of the uninsured that will fall into a gap between the traditional Medicaid program and the subsidized insurance market, there is a question as to whether those individuals would be subject to the penalty or "tax." States should engage CCIIO in a dialogue about these individuals as well to determine what the impact to them might be.

4. The ACA planned for a phase-out of the Disproportionate Share Hospital (DSH) payments, based on the premise that nearly everyone would have coverage of some kind. If a state does not move forward with Medicaid expansion, what happens to its DSH payments?

One of the primary cost "savers" within ACA was a phase-out of the DSH program. This phase-out was to be triggered by a reduction in the uninsured population within a state and would have resulted in a reduction by 50 percent or more in a state's DSH allotment. It can be reasonably assumed that if the trigger is not met (i.e., a reduction by 45 percent in a state's uninsured population) that the reduction in DSH would not occur. However, this interpretation should also be confirmed by state officials through discussion with CCIIO.

5. If a state does not move forward with Medicaid expansion, is it worth it to operate a state-based exchange or should the state simply default to the federal option?

Finally, once a decision is made regarding Medicaid expansion, a state may be left with a decision or reconsideration of its strategy for an HBE. The reality is that nationally the vast majority of the newly insured under ACA would have been enrolled in Medicaid under the expanded program. If the program is not expanded, the uptake into an HBE will be greatly reduced and the population that is left may not provide the critical mass necessary to warrant a state-based exchange or make it economically sustainable. Once a state makes a decision regarding the Medicaid program, it is recommended that analysis previously conducted as part of initial HBE planning be reevaluated to determine if a state-based exchange is still a viable direction.
